

FOR OFFICE USE ONLY - Ver 3.9

Proposal Number	NUP
Advisor Name	
Advisor Number	

For Existing Customer	Customer I.D.	Policy no.
For Bancassurance Channel Only		
Bank Partner	Bank Branch Code	
Customer Segment	SP Certificate No	



SECTOR	<input type="checkbox"/> Urban	<input type="checkbox"/> Rural	<input type="checkbox"/> Social	<input type="checkbox"/> NRI	Product Name	
Unique Village Code						

PROPOSAL DEPOSIT DETAILS		Voucher Number	
Cheque/DD No.		Date	
Amount		Drawn on	

STAFF ☐ HNI ☐

Proposal Form

Notes:

- The proposer should be satisfied with the details of the product(s) and must pay specific attention to the Key Features brochure of the product(s).
- Receipt by the Company of the completed proposal and initial payment does not create any obligation on the part of the Company to underwrite the risk, and the Company shall not be liable until such time it has underwritten the risk and issued the policy.
- Units shall be allocated on the day the proposal is completed and results into a policy by adjustment of application money towards premium. (Applicable For Ulip Policy)
- The initial payment must accompany this proposal and may be paid by cash, crossed cheque or demand draft made payable to **Aviva Life Insurance Account Proposal Number "....."** at the location of the Branch Office or in any other manner as may be approved by the Company.
- In case of cash deposits, refunds (if any) will be made by cheque only.
- In accordance with Section 45 of the Insurance Act 1938, as amended from time to time, the proposer is required to give full and accurate information to enable the Company underwrite this proposal.
- Proof of age is mandatory.
- Please counter sign on alterations/overwriting/ink change, if any, made in the proposal form.
- The advisor is not authorised to collect cash/bearer cheque that is meant for the company
- In the event the Proposal is withdrawn by the Proposer before issuance of the Policy, the Company shall refund the application money after deduction of the expenses incurred on medical examination of the Proposer, if applicable.
- If a particular section is not applicable to you please write "NA" or "-" and proposal form has to be completely filled.
- Aviva shall contact you for the verification purposes, which is basis your Contactability.
- NAV would be the later of date of credit / date of underwriting / date of verification, whichever is later.
- Benefit illustration is an integral part of this application. This needs to be signed by the policyholder.
- Riders are not mandatory and are available at an extra cost.

1. Details of the First Life to be insured (Please complete in CAPITAL LETTERS)

1.1 Full Name : THIS IS HOW YOUR NAME WILL APPEAR ON THE POLICY CERTIFICATE. PLEASE LEAVE A SPACE BETWEEN EACH PART OF THE NAME.

Title : Mr. / Mrs. / Ms. / Dr.	First Name
Middle Name	
Surname	

Affix Photo

1.2 Maiden Name (in case of married female life to be insured)

Title : Ms. / Dr.	First Name
Middle Name	
Surname	

1.3 Father's Name

Title : Mr. / Dr.	First Name
Middle Name	
Surname	

1.4 Date of Birth

Date	Month	Year

1.5 Gender

☐ Male
☐ Female

1.6 Marital Status

☐ Unmarried ☐ Married
☐ Widow(er) ☐ Divorced

1.7 No. of Children

☐ 1 ☐ 2 ☐ 3
Greater than 3 ☐ NA

1.8 Nationality

☐ Indian ☐ Foreign National¹ ☐ Person of Indian Origin¹ ¹Specify Nationality _____

1.9 Residential Status

☐ Residing in India ☐ Not Residing in India¹ ¹Specify Country of residence _____

1.10 Communication Address

☐ Residence ☐ Permanent ☐ Office

1.11 Current Residential Address

(PLEASE LEAVE A SPACE BETWEEN EACH PART OF THE ADDRESS)

Address (Please include c/o, s/o, w/o, d/o, h/o, f/o wherever necessary)	
Landmark	Pin Code
City/Village	District
	State
Phone	Mobile
STD Code	Phone No.

¹If you are an Indian or a Person of Indian Origin, not residing in India, please fill the NRI questionnaire.

1.12 Permanent Address (IF DIFFERENT FROM CURRENT RESIDENTIAL ADDRESS)

Address (please include c/o, s/o, w/o, d/o, h/o, f/o wherever necessary)

Landmark

City/Village

Phone

STD Code

Phone No.

Pin Code

District

State

Mobile

1.13 Educational Qualification

☐ Post Graduate ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ Below 12th ☐ Others (Specify) _____

1.14 Occupation

☐ Salaried ☐ Business Owner ☐ Self-employed ☐ Student

☐ Housewife ☐ Retired/Pensioner ☐ Agriculturist ☐ Others (Specify) _____

If student (a) Course presently pursuing _____, (b) Name of Institution _____, (c) Duration of Course _____

Work details of life to be insured

1.15 Exact Nature of Duties (Give Description e.g: Trading In Food Grain / Textiles, Driving Taxi / Business of Diamond Export etc.)

1.16 Your Designation

1.17 Is your occupation associated with any specific hazard (e.g. Chemical factory, mines, explosives, corrosive chemicals etc.) ☐ YES ☐ NO

If yes, please give details.

1.18 Name of Organisation/Business

Address

Landmark

City

Phone

STD Code

Phone No.

Pin Code

State

Mobile

1.19 Life Assured's Annual Income Rs. : _____ If not earning, Parent's/Spouse's Annual Income Rs. _____

1.20 E-mail ID

1.21 Age proof ☐ School/College Certificate ☐ Municipal Records ☐ Defence ID Card ☐ Passport ☐ Others (Specify) _____

1.22 Income Tax PAN Number

2. Details of the Second Life to be insured (Please complete in CAPITAL LETTERS) if applicable

2.1 Full Name : THIS IS HOW YOUR NAME WILL APPEAR ON THE POLICY CERTIFICATE. PLEASE LEAVE A SPACE BETWEEN EACH PART OF THE NAME.

Title : Mr. / Mrs. / Ms. / Dr.

First Name

Middle Name

Surname

2.2 Maiden Name (in case of married female life to be insured)

Title : Ms. / Dr.

First Name

Middle Name

Surname

2.3 Father's Name

Title : Mr. / Dr.

First Name

Middle Name

Surname

2.4 Date of Birth

Date

Month

Year

2.5 Gender ☐ Male ☐ Female

2.6 Marital Status ☐ Unmarried ☐ Married ☐ Widow(er) ☐ Divorced

2.7 No. of Children ☐ 1 ☐ 2 ☐ 3 ☐ Greater than 3 ☐ NA

2.8 Nationality ☐ Indian ☐ Foreign National¹ ☐ Person of Indian Origin¹ ¹Specify Nationality _____

2.9 Residential Status ☐ Residing in India ☐ Not Residing in India¹ ¹Specify Country of residence _____

2.10 Educational Qualification

☐ Post Graduate ☐ Graduate ☐ Diploma ☐ 12th Pass ☐ Below 12th ☐ Others (Specify) _____

2.11 Occupation

☐ Salaried ☐ Business Owner ☐ Self-employed ☐ Student

☐ Housewife ☐ Retired/Pensioner ☐ Agriculturist ☐ Others (Specify) _____

If student (a) Course presently pursuing _____, (b) Name of Institution _____, (c) Duration of Course _____

2.12 Relationship with the first life to be insured

Work details of life to be insured

2.13 Exact Nature of Duties

2.14 Your Designation

2.15 Is your occupation associated with any specific hazard (e.g. Chemical factory, mines, explosives, corrosive chemicals etc.) ☐ YES ☐ NO

If yes, please give details.

¹If you are an Indian or a Person of Indian Origin, not residing in India, please fill the NRI questionnaire.

3. Details of the Proposer (if different from life to be insured)

3.3 Father's Name / Husband's Name

Title : Mr. / Dr.	First Name
<input type="text"/>	<input type="text"/>
Middle Name	Surname
<input type="text"/>	<input type="text"/>

3.8 Nationality ☐ Indian ☐ Foreign National¹ ☐ Person of Indian Origin¹ ¹Specify Nationality_____

3.10 Address of Proposer (PLEASE LEAVE A SPACE BETWEEN EACH PART OF THE ADDRESS)

3.11 Relationship of Proposer with the Life to be Insured

Work details of proposer

3.14 Your Designation _____

Figure 1: Percentage of respondents who answered 'Yes' to the question 'Do you have a good understanding of the risks of the investment?' for the Control, Information, and Decision groups over time.

¹If you are an Indian or a Person of Indian Origin, not residing in India, please fill the NRI questionnaire.

5.17 Are you the holder of bank account in your own name? ☐ Yes ☐ No If yes, give bank details (Mandatory incase of Direct Debit / Credit Card / ECS)

Bank Account Number

Credit Card Number

Bank Name

Account Type

☐ Saving Account ☐ Current Account ☐ NRO/NRE

MICR Code (9 digits)

Address of Branch

5.18 For Traditional Products only

Do you want back dating of the policy

☐ Yes ☐ No

If yes, Date of commencement
(within current Financial Year)

¹Monthly frequency is acceptable only through Direct Debit and Electronic Clearing System (ECS) mode of payment

²Indexation protects the purchasing power of the maturity value or death benefit so that your savings remain a meaningful amount throughout the duration of the policy. You have the option of increasing the regular premium, sum insured and rider benefits by an inflation adjustment in line with the increase in the Wholesale Price Index, **without any evidence of health**.

³Cash can only be deposited at Aviva Branch Office by the proposer or by his/her representative. Cash receipt will be issued only at Aviva Branch Office.

⁴Please check with your advisor if these facilities are available. If yes, please complete the Direct Debit Instructions Mandate, relevant Charge Slip or ECS Mandate Form, as applicable. In case of ECS, initial payment must be made by cheque / cash.

⁵Systematic Transfer Plan (STP) is available only on select products. Please refer to the key feature document of your selected product for more details. Opting for the STP option will provide you with a policy information and transaction login ID and Password to enable you to access your policy account on the web.

6. Family and personal details of the life to be insured

Personal Details

6.1 Your Height / Weight

	First Life	Second Life																																																																																
Height (in cms)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																									<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																								
Weight (in kgs)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																									<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																																								
Have you experienced any change in weight of more than 5 kgs in the past 1 year?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																
If yes, how many kgs of	Loss <input type="checkbox"/> Gain <input type="checkbox"/> _____ kgs.	Loss <input type="checkbox"/> Gain <input type="checkbox"/> _____ kgs.																																																																																
Reason for the same _____	_____	_____																																																																																

6.2 Health & Activity Section

If you answer YES to questions A,B,C (ii), D(ii), E,F, I (ii) & I (iii) please provide us with further background information in the table provided below. The information given will allow us to come to a decision without having to delay your proposal for further queries.

	First Life	Second Life
A. Are you currently receiving any medical treatment or are you awaiting medical or surgical consultation, test or investigation? (You need not disclose matters relating to uncomplicated pregnancy, common colds, influenza, hay-fever or any minor ailment requiring a single consultation)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
B. Have you ever had any medical or surgical treatment, including investigations, tests, scans or X-Ray for any of the following illnesses or medical conditions:		
i. High blood pressure, angina, heart attack, stroke or any other disorder of heart or circulation?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
ii. Any form of cancer, tumor or growth?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
iii. Disorder of skin or lymph glands?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
iv. Diabetes, kidney or liver problem?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
v. Colitis or any other stomach, bowel or bladder problem?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
vi. Multiple sclerosis, epilepsy, tremor, numbness, double vision or giddiness?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
vii. Mental or nervous illness (including depression) lasting for more than 3 months and/or requiring more than 10 consecutive days off work?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
viii. Asthma, bronchitis, pneumonia, TB or any other respiratory or lung disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
ix. Ulcer, chronic diarrhoea, hepatitis or jaundice?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
x. Congenital disorder, anemia, bleeding or blood disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
xi. Reproductive organ or prostrate disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
xii. Arthritis, gout or joint pain, muscle, bone fracture or disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
xiii. AIDS or AIDS related complex or test indicating presence of HIV?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
xiv. Any other illness, surgery or injury?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
xv. Do you have any bodily deformities?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
xvi. Do you have any health symptoms or complaints for which a physician has not been consulted or treatment received? eg: persistent fever, unexplained weight loss, loss of appetite, pain, swelling etc.?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

C. Tobacco / Smoking

	First Life	Second Life
(i) Do you smoke/consume or have you ever smoked/consumed cigars, cigarettes, beedies or any other tobacco products (pan masala etc.)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, how many cigarettes/cigars/beedies/tobacco pouches do you consume per day?		
For how long		
(ii) Have you ever sought or been given medical advice to reduce/abstain from smoking/tobacco consumption?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

D. Alcohol

(i) Do you take or have you ever taken alcohol?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, how many units of alcohol do you consume per week? (1 unit=1/2 bottle of beer/1 glass of wine/1 peg measure of spirits)	Unit _____	Unit _____
For how long		
(ii) Have you ever sought or been given medical advice to reduce the level of/abstain from drinking?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

E. Drug Abuse

(i) Are you now using or have you ever used any of following drugs like amphetamines, barbiturates, cannabis, cocaine, hallucinogens, herbs, opiates, sedatives, solvents, etc, other than for treatment of a medical condition under proper medical supervision?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes pls provide full detail including name of drug & date when usage commenced and ceased.		

F. Have you been required to take time off from work on health grounds?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
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G. Apart from work, has your health placed any restrictions on your normal daily activities?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	--

H. Do you have any history of criminal charges / proceeding against you and / or are there any criminal charges or proceeding pending against you currently or in the past and / or were you convicted in any criminal proceeding and/or are on bail / probation / suspended sentence? If yes pls provide detail including dates and reason and nature of charges.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
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I. For Female Lives only:

(i) Are you pregnant?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, number of weeks pregnant	__ __	__ __
(ii) Have you had, or do you have any complications of pregnancy at present or in the past?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
(iii) Have you had, or do you have any gynaecological problem?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
(iv) For married females, spouse insurance details (total sum insured in Rs.)	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __

J. Are you or your Nominee a Politically Exposed Person (PEP) ?

Politically Exposed Persons(PEP)are individuals who are or have been entrusted with prominent public functions, for example Heads/Ministers of Central/State government, Senior politicians , Senior government/Judicial /Military officers, Senior Executive of State owned Corporations, important political party officials & immediate family member of above persons(Spouse, Children, Parents and Siblings, In-laws)

YES ☐ NO ☐

K. If you hold any government card / ID which is specifically issued for economic and financially backward strata of the society like BPL /APL Card, MNREGA Card etc., please give details (please state NA or not applicable, if this is not applicable to you) _____

First Life

Question No.	Please provide complete details for all the above questions answered "YES", mentioning exact nature of medical condition/illness/injury, dates, reason, cause, symptoms, diagnosis, treatment, results with name & address of the attending physician

Second Life

Question No.	Please provide complete details for all the above questions answered "YES", mentioning exact nature of medical condition/illness/injury, dates, reason, cause, symptoms, diagnosis, treatment, results with name & address of the attending physician

Family history of the life to be insured

L. Please give details of family members of the life to be assured. Also, in case any of the family members are either suffering or have suffered or have died from heart disease, stroke, high blood pressure, diabetes mellitus, any form of eye disease, cancer, kidney disease, paralysis or any hereditary / familial disorders, any communicable disease such as tuberculosis, etc. or any other disease not mentioned above; mention the same in the following table.

(KINDLY REFER TO THE ABOVE PARAGRAPH FOR FILLING THE TABLE)

First life	If Alive	If Deceased		
Family member	Health Status	Current Age	Cause of Death	Age at Death
Father				
Mother				
Brother(s)*				
Sister(s)*				

(KINDLY REFER TO THE ABOVE PARAGRAPH FOR FILLING THE TABLE)

Second life	If Alive	If Deceased		
Family member	Health Status	Current Age	Cause of Death	Age at Death
Father				
Mother				
Brother(s)*				
Sister(s)*				

* If you do not have any siblings alive or deceased then please write "NA" or "-"

		First Life	Second Life
6.3 Do you have a family doctor (A family doctor is a doctor that you consult or have consulted regularly for medical ailments.)		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, please give family doctor's details			
6.4 Family Doctor's Details			
Name			
Address			
City		State	Pin Code
Phone		Mobile	
	STD Code	Phone No.	

7. Hobbies/Travel Details

	First Life	Second Life
7.1 Do you take part in any form of motor sport, climbing, diving, caving, flying private aircraft, sky diving, hang gliding etc.?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
(If yes, please give details)		
7.2 Have you travelled abroad (other than Canada, Australia, New Zealand, USA, EU and GCC) in the last five years or have you any prospect of doing so as part of your current job? (If yes, please complete the Travel & Residency Questionnaire)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

8. Insurance Details

		First Life	Second Life																					
8.1 Are you holding any life, health or critical illness insurance policies (in-force/paid-up) in your name or submitted any simultaneous proposal with us or any other life insurance company which is under consideration?		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>																					
If yes, give details of existing insurance cover of in-force/paid-up policies in the name of life to be insured. Please include policies from Aviva Life Insurance as well. (If more than two policies exist, then give details of all the policies by attaching an addendum).																								
First Life																								
a.	<table border="1"> <thead> <tr> <th>Name of the Insurer</th> <th>Type of Policy</th> <th>Term of Policy</th> <th>Sum Assured/Paid-up Sum Assured</th> <th>Year of Issue</th> <th>Whether accepted at ordinary rates. If not, state the extra charge imposed</th> <th>Riders Covered</th> </tr> </thead> <tbody> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>	Name of the Insurer	Type of Policy	Term of Policy	Sum Assured/Paid-up Sum Assured	Year of Issue	Whether accepted at ordinary rates. If not, state the extra charge imposed	Riders Covered																
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b. Total annual premium of Life Insurance Policies in your own name (Rs. Figures)		<table border="1"> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table>									<table border="1"> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table>													
c. Have you ever made any claim on your critical illness or health policy other than for minor ailments from which you have fully recovered?		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>																					
(If yes, please give details)																								
d. Has your proposal or application for reinstatement you have made for life, health or critical illness cover been declined, postponed or accepted on special terms or have you ever withdrawn an application?		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>																					
(If yes, please give details)																								
e. Are you paying premium for life insurance policies on any other life.		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>																					
If yes, Total annual premium (Rs. in figures)																								
8.2 Family Insurance Details (To be completed if the Life to be Insured is student or non-earning individual)																								
The following information is required only in respect of the life to be insured and not the proposer.																								
	First Life					Second Life																		
	Name of the company	Policy Number/s	Sum Assured	Status	Year of Issue	Name of the company	Policy Number/s	Sum Assured	Status	Year of Issue														
Father																								
Mother																								
Spouse																								
Brother/Sister																								
Brother/Sister																								
Brother/Sister																								

9. Declaration & Authorization

- 1 I/We declare and confirm that all the replies to the questions in the proposal, the details furnished in the enclosed questionnaires and the reports of any medical examination are provided to the best of my/our knowledge and I/we have fully understood the nature of the questions and importance of disclosing all material information while answering such questions. I / We are aware that the policy is sourced on the basis of limited health questions and I/ We declare that no material information required by Aviva Life Insurance Company India Limited (hereinafter referred to as "the Company") to assess the risks on my/our life is withheld with me/us.
- 2 I/We undertake to notify the Company of any change in the state of health of the life to be insured or as to my/his/her occupation subsequent to the signing of this proposal and before the acceptance of the risk by the Company.
- 3 I/we also certify that I/we have read and understood the Benefits Illustrations and the sales literature as published by the Company that were handed over to me/us along with this proposal form.
- 4 I/We hereby authorise the Company to conduct screening/confirmation/reconfirmation of my/our health status through medical examinations which may include Laboratory tests, Cardiac, Radiological investigations and other medical tests including blood tests to detect bacterial/viral/fungal infections. I/We hereby give my/our consent to undergo HIV ½ test by ELISA method. I/We am aware that this test is only for screening purpose and not confirmatory for HIV/AIDS. Based on the results of these test, the Company reserves the right to accept, decline or offer alternate terms on my/our proposal for life insurance. I/We understand that these tests are being conducted as per the Company's underwriting policy for assessing my/our risk profile and I/We are hereby giving our consent for the same.
- 5 In order to enable the Company to assess the risk under this proposal and any time thereafter, I/We hereby authorize the past and present employer(s)/ business associates of mine, my medical practitioner/ hospital/ medical source/ any life and non-life Insurance Company/ organization or Life Insurance Association to release to the Company the records of employment/ business or other details of mine as may be considered relevant for acceptance or otherwise of the proposal.
- 6 In order to enable the Company to assess the risk under my/our proposal and any time thereafter, solely for the purpose of issuance and administration of the policy resulting from this proposal I/We agree and declare that the Company may without any reference to me/us (or to my/our beneficiary, as the case may be) disclose any information contained in the proposal, the annexure, in the reports of any medical examination / laboratory tests or in the documents submitted by me / or procured by the Company to any other insurer or to any reinsurer, to any claims investigator or any service provider engaged by the Company. Likewise the Company may make available copies of the proposal form, annexures, reports of any medical examination laboratory tests or any documents submitted by me/us (or, as the case may be, by my/our beneficiary) or procured by the Company to any insurer to any claims investigator or any service provider engaged by the Company for servicing the policies. So also the Company may without any reference to me/us (or, as the case may be, to my/our beneficiary) furnish to any court / tribunal or other authority any such information or proposal, annexure, reports or documents as may be required of the Company or as may be considered necessary by the Company.
- 7 I/ We declare that the deposit towards the first premium and the renewal premium to be paid under the Policy are from legally assessed source of Income. In case the premium is paid from any other account other than my /our own, I/we shall ensure that such payment is permitted under Section 80C/80CCC of the Income Tax Act, 1961. I/We declare that in case I/we are found guilty of any offence relating to Anti Money Laundering law, the Company will be in within the rights to cancel the policy issued pursuant to this proposal & forfeit all the premium.
- 8 I/ We hereby understand and agree that Fraud or Misrepresentation would be dealt with in accordance with the provisions of Section 45 of Insurance Act, 1938 as amended from time to time.
- 9 I/We agree and confirm to the use of electronic medium, including email, as a mode of communication, in relation to this proposal / resulting policy, from and to the Company.
- 10 In case, for any reason this proposal has not been filled in by me, I/we hereby declare that the contents of this application for insurance, have been fully explained to me/us & I/we have fully understood the significance of the proposed contract. This proposal form shall be a part of the life insurance policy contract, in case of its acceptance by the Company.

Please tick the suitable timings to contact you:

☐ 9 AM - 12 PM

☐ 12 PM - 4 PM

☐ 4 PM - 7 PM

First Life

Signature* / thumb impression* of the life to be insured

Date: DD MM YYYY

Place : _____

Second Life

Signature* / thumb impression* of the life to be insured

Date: DD MM YYYY

Place : _____



Signature* / thumb impression* of the proposer
(if different from the life to be insured)

Date: DD MM YYYY

Place : _____

10. Declaration by the person filling in the form (in case of signature in vernacular language, thumb impression and/or in case the proposal has not been filled in by the proposer).

I hereby declare that I have fully explained the contents of the proposal form to the life to be insured/proposer and that he/she has fully understood the same and I have truthfully recorded the answers given by the life to be insured/proposer. Enclose identity proof of the declarant.

Declarant's Name and Address

Pin Code

Signature of declarant

Signature of Advisor/SP

Handwritten Vernacular Declaration

Signature of life to be insured/proposer

11. Section 41 & 45 of Insurance Act 1938

41. (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

45. (1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.

(2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud:

Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision is based.

(3) Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer:

Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the policyholder is not alive.

(4) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued:

Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based:

Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation.

(5) Nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.

For a complete text of Section 45 please refer to Insurance Act, 1938 as amended from time to time.



A Joint Venture between Dabur Invest Corp. and Aviva International Holdings Limited

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